		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0000786

Facility Name: VERMILION MANOR NURSING HOME

Address: 14792 CATLIN TILTON ROAD (Number) DANVILLE (City) 61834 (Zip Code)

County: VERMILION

Telephone Number: 217-443-6430 **Fax #** 217-443-1558

IDPA ID Number: 37-6002224-001

Date of Initial License for Current Owners: 01/01/1974

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: EDIE HESSER **Telephone Number:** 217-443-6430

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/03 to 11/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) EDIE HESSER
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) SEE ATTACHED ACCOUNTANT'S REPORT
(Firm Name & Address) CLIFTON-GUNDERSON LLP
2 E MAIN STREET, SUITE 120, DANVILLE, IL 61832
(Telephone) 217-442-1643 Fax # 217-443-5470

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	138	48,434	1
2		Skilled Pediatric (SNF/PED)			2
3	187	Intermediate (ICF)	95	36,699	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	233	85,133	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,297	2,049	7,030	11,376	8
9	SNF/PED					9
10	ICF	39,534	13,717	1,165	54,416	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,831	15,766	8,195	65,792	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.28%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1974

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 6,720

Medicare Intermediary ADMINSTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: 12/01/03-11/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	425,429	40,822	20,338	486,589		486,589		486,589			1
2	Food Purchase		334,589		334,589	(3,100)	331,489	(14,982)	316,507			2
3	Housekeeping	132,471	30,187		162,658		162,658		162,658			3
4	Laundry	94,605	18,273		112,878		112,878		112,878			4
5	Heat and Other Utilities			199,602	199,602	(364)	199,238	(11,470)	187,768			5
6	Maintenance		20,984	51,845	72,829		72,829	122,550	195,379			6
7	Other (specify):* Waste Disposal			13,914	13,914		13,914		13,914			7
8	**TOTAL General Services**	652,505	444,855	285,699	1,383,059	(3,464)	1,379,595	96,098	1,475,693			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000	(24,000)						9
10	Nursing and Medical Records	3,792,019	682,388	217,463	4,691,870	(16,054)	4,675,816		4,675,816			10
10a	Therapy			443,684	443,684	(3,189)	440,495		440,495			10a
11	Activities	85,836	957		86,793		86,793		86,793			11
12	Social Services	118,858	2,366	325	121,549		121,549		121,549			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,996,713	685,711	685,472	5,367,896	(43,243)	5,324,653		5,324,653			16
	C. General Administration											
17	Administrative	63,599			63,599		63,599		63,599			17
18	Directors Fees							3,816	3,816			18
19	Professional Services			5,220	5,220		5,220	3,500	8,720			19
20	Dues, Fees, Subscriptions & Promotions			9,901	9,901		9,901		9,901			20
21	Clerical & General Office Expenses	155,250	19,830	31,434	206,514		206,514	10,091	216,605			21
22	Employee Benefits & Payroll Taxes			329,205	329,205	3,100	332,305	395,012	727,317			22
23	Inservice Training & Education			1,200	1,200		1,200		1,200			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,692	5,692		5,692		5,692			25
26	Insurance-Prop.Liab.Malpractice			69,394	69,394		69,394		69,394			26
27	Other (specify):* BAD DEBT			73,839	73,839		73,839	(73,839)				27
28	**TOTAL General Administration**	218,849	19,830	525,885	764,564	3,100	767,664	338,580	1,106,244			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,868,067	1,150,396	1,497,056	7,515,519	(43,607)	7,471,912	434,678	7,906,590			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number VERMILION MANOR NURSING HOME #0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			193,070	193,070		193,070		193,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,976	1,976		1,976		1,976			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			195,046	195,046		195,046		195,046			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					24,000	24,000		24,000			39
40	Barber and Beauty Shops					364	364		364			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,780	127,780		127,780		127,780			42
43	Other (specify):* EXCEPTIONAL CARE EXPENSES					19,243	19,243		19,243			43
44	**TOTAL Special Cost Centers**			127,780	127,780	43,607	171,387		171,387			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,868,067	1,150,396	1,819,882	7,838,345		7,838,345	434,678	8,273,023			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,982)	V2		4
5	Telephone, TV & Radio in Resident Rooms	(11,470)	V5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,839)	V27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (100,291)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	534,969		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 534,969		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 434,678		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		364	V5(3)	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program	X		19,243	V10,10a	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 19,607		47

STATE OF ILLINOIS

VERMILION MANOR NURSING HOME

ID# 0000786

Report Period Beginning: 12/01/03

Ending: 11/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON PATIENT MEALS	$ (14,982)	2	1
2	CABLE TV	(11,470)	5	2
3	BAD DEBT	(73,839)	27	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(100,291)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 **Report Period Beginning:** 12/01/03 **Ending:** 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,982)	0	0	0	0	0	0	0	0	0	0	(14,982)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,470)	0	0	0	0	0	0	0	0	0	0	(11,470)	5
6	Maintenance	0	122,550	0	0	0	0	0	0	0	0	0	122,550	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(26,452)	122,550	0	0	0	0	0	0	0	0	0	96,098	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	3,816	0	0	0	0	0	0	0	0	0	3,816	18
19	Professional Services	0	3,500	0	0	0	0	0	0	0	0	0	3,500	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	10,091	0	0	0	0	0	0	0	0	0	10,091	21
22	Employee Benefits & Payroll Taxes	0	395,012	0	0	0	0	0	0	0	0	0	395,012	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(73,839)	0	0	0	0	0	0	0	0	0	0	(73,839)	27
28	**TOTAL General Administration**	(73,839)	412,419	0	0	0	0	0	0	0	0	0	338,580	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(100,291)	534,969	0	0	0	0	0	0	0	0	0	434,678	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 **Report Period Beginning:** 12/01/03 **Ending:** 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(100,291)	534,969	0	0	0	0	0	0	0	0	0	434,678	45

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		VERMILION COUNTY	DANVILLE	COUNTY GOVERNMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE-PAYROLL	$	VERMILION COUNTY	N/A	$ 122,550	$ 122,550	1
2	V	18	COMMITTEE		VERMILION COUNTY	N/A	3,816	3,816	2
3	V	19	AUDIT		VERMILION COUNTY	N/A	3,500	3,500	3
4	V	21	ACCOUNTING/PAYROLL		VERMILION COUNTY	N/A	10,091	10,091	4
5	V	22	GROUP INSURANCE		VERMILION COUNTY	N/A	13,115	13,115	5
6	V	22	FICA		VERMILION COUNTY	N/A	260,903	260,903	6
7	V	22	IMRF		VERMILION COUNTY	N/A	120,994	120,994	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 534,969	$ * 534,969	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: VERMILION COUNTY, IL
Street Address: 6 N VERMILION
City / State / Zip Code: DANVILLE, IL 61832
Phone Number: (217-431-2553
Fax Number: (217-431-6714

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE - PAYROLL		1		$ 122,550	$	1	$ 122,550	1
2	18	COMMITTEE		1		3,816		1	3,816	2
3	19	AUDIT		1		3,500		1	3,500	3
4	21	ACCOUNTING/PAYROLL		1		10,091		1	10,091	4
5	22	GROUP INSURANCE		1		13,115		1	13,115	5
6	22	FICA		1		260,903		1	260,903	6
7	22	IMRF		1		120,994		1	120,994	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 534,969	$		$ 534,969	25

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LOAN FROM COUNTY	X		OPERATING EXPENSES	N/A	1/1/97	200,000	10,060	N/A	0.0400	1,976	6
7												7
8												8
9	TOTAL Facility Related						$ 200,000	$ 10,060			$ 1,976	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 200,000	$ 10,060			$ 1,976	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	N/A	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	N/A	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	N/A	8
	2000	N/A	9
	2001	N/A	10
	2002	N/A	11
	2003	N/A	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME VERMILION MANOR NURSING HOME COUNTY VERMILION

FACILITY IDPH LICENSE NUMBER 0000786

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,800 B. General Construction Type: Exterior BRICK Frame SINGLE STORY Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	INFORMATION NOT AVAILABLE			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1974	1974	$ 2,290,108	$ 57,253	40	$ 57,253	$	$ 1,765,282	4
5	95		1979	1979	1,961,500	49,038	40	49,038		1,245,766	5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT/GARAGE			1980	16,200		10			16,200	9
10	CONSTRUCTION			1980	92,111	2,303	40	2,303		57,573	10
11	FINAL CONSTRUCTION			1981	6,000	150	40	150		3,600	11
12	PUMP			1982	9,414		10			9,414	12
13	ROOF			1982	40,042		10			40,042	13
14	ROOF			1983	39,569		10			39,569	14
15	ROOF			1984	52,663		10			52,663	15
16	WATER HEATER			1985	27,463		10			27,463	16
17	WATER LINE			1985	5,290		10			5,290	17
18	DRIVEWAY			1985	4,200		10			4,200	18
19	LINT CATCHER			1986	5,981		10			5,981	19
20	PARKING LOT			1986	26,927		10			26,927	20
21	ROOF/DUCT WORK			1986	6,114		10			6,114	21
22	FENCE			1986	609		10			609	22
23	PVC RUB RAILS			1988	2,821	141	20	141		2,339	23
24	CERAMIC TILES			1988	6,872	344	20	344		5,588	24
25	TIME CLOCK/COMPUTER			1988	2,030	101	20	101		1,638	25
26	INCREMENTAL CONDITIONER			1988	17,116	856	20	856		13,694	26
27	WATER METER			1988	1,457		15			1,457	27
28	400 AMP LINE			1988	3,400	170	20	170		2,819	28
29	CANOPY REPAIR			1988	12,075	604	20	604		9,963	29
30	DOOR O MATIC			1989	1,763	88	20	88		1,380	30
31	AIR CONDITIONER			1989	146,368	7,318	20	7,318		105,866	31
32	HOT WATER STORAGE TANK			1990	4,589	229	20	229		3,363	32
33	CAPITAL IMPROVEMENT			1990	18,139	906	20	906		13,378	33
34	AIR CONDITIONER UNITS			1990	21,470	1,074	20	1,074		15,673	34
35	PUMPS			1991	1,700	85	20	85		1,169	35
36	AIR CONDITIONERS			1991	9,217	461	20	461		6,184	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIRE DOORS AND RELATED IMPROVEMENTS	1991	$ 4,354	$ 218	20	$ 218	$	$ 2,863	37
38	PLUMBING	1992	7,162	358	20	358		4,684	38
39	AIR HANDLER/CORNER GUARDS	1991	4,028	201	20	201		2,617	39
40	ROOF REPAIR	1991	10,500	525	20	525		7,263	40
41	FIRE HYDRANT	1991	2,185	109	20	109		1,509	41
42	GENERATOR	1992	70,808	3,540	20	3,540		44,771	42
43	PLUMBING	1992	62,884	3,144	20	3,144		39,712	43
44	LIGHT FIXTURES	1992	1,395	70	20	70		873	44
45	AIR CONDITIONERS	1992	24,201	1,210	20	1,210		14,979	45
46	ROOF REPAIRS	1993	38,982	1,949	20	1,949		22,318	46
47	WALK IN FREEZER	1993	11,400	570	20	570		6,650	47
48	MASTER STATION IMPROVEMENTS	1993	3,215	214	20	214		2,463	48
49	SMOKING ROOM	1993	6,511	325	20	325		3,717	49
50	LOUNGE WALL	1993	1,004	50	20	50		564	50
51	KITCHEN IMPROVEMENTS	1993	9,952	498	20	498		5,621	51
52	80 GALLON WATER HEATER	1994	5,987	299	20	299		3,191	52
53	ACTIVATOR PARTS	1994	1,190	59	20	59		632	53
54	DAMPERS	1994	3,082	154	20	154		1,605	54
55	CALL SYSTEM	1994	3,427	171	20	171		1,712	55
56	GARAGE	1994	13,254	663	20	663		6,628	56
57	BOOSTER HEATER	1995	4,320	432	10	432		4,212	57
58	CALL LIGHT SYSTEM	1995	3,577	358	10	358		3,459	58
59	FOLDING PARTITION	1995	4,880	488	10	488		4,392	59
60	REWIRE GARAGE	1995	650	33	20	33		295	60
61	EXHAUST SYSTEM	1996	5,347	535	10	535		4,769	61
62	CONCRETE WORK - FRONT ENTRANCE	1996	1,050	70	15	70		589	62
63	CONCRETE WORK - DRIVEWAYS	1996	10,170	678	15	678		5,650	63
64	CANOPY	1996	19,619	1,308	15	1,308		10,682	64
65	TILE REPLACEMENT	1996	1,129	113	10	113		904	65
66	ROOF REPAIR	1997	30,645	1,532	20	1,532		11,363	66
67	AIR CONDITIONER UNITS	1997	15,320	766	20	766		5,554	67
68	REPAIR DRIVE	1997	2,900	290	10	290		2,127	68
69	WATER HEATER	1998	6,200	620	10	620		3,875	69
70	TOTAL (lines 4 thru 69)		$ 5,224,536	$ 142,671		$ 142,671	$	$ 3,723,447	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,224,536	$ 142,671		$ 142,671	$	$ 3,723,447	1
2	CAPITAL IMPROVEMENT	1998	1,013	102	10	102		608	2
3	ROOF	1998	21,809	2,181	10	2,181		13,268	3
4	AIR CONDITIONER UNITS	1998	9,160	458	20	458		2,786	4
5	AIR CONDITIONER UNITS	1998	8,580	429	20	429		2,574	5
6	NEW ROOF	1999	22,973	1,149	20	1,149		6,128	6
7	AIR CONDITIONER UNITS	1999	49,921	2,496	20	2,496		13,312	7
8	CANOPY REPAIR	1999	7,630	382	20	382		2,005	8
9	GENERATOR	2000	7,951	398	20	398		1,824	9
10	WATER HEATER	2000	8,368	418	20	418		1,811	10
11	CONDENSER	2000	2,350	118	20	118		501	11
12	CANOPY REPAIR	2001	7,700	513	15	513		1,967	12
13	HOT WATER HEATER	2001	1,634	163	10	163		584	13
14	ELECTRIC BOOSTER HEATER	2001	1,639	164	10	164		560	14
15	BOILER REPAIR	2001	23,800	1,587	15	1,587		5,024	15
16	AIR CONDITIONER UNITS	2002	8,367	418	20	418		836	16
17	LIGHTING/C SECTION RENOVATION	2002	8,402	420	20	420		840	17
18	PARKING LOT IMPROVEMENTS	2003	4,800	320	15	320		400	18
19	ROOFING	1994	38,981	1,949	20	1,949		19,490	19
20	BOILERS (USED)	2004	2,529	154	15	154		154	20
21	CARPETING - ADMIN AREA	2004	1,564		10				21
22	WATER HEATER	2004	4,807		10				22
23	SPRINKLER SYSTEM	2004	103,957		10				23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,572,471	$ 156,490		$ 156,490	$	$ 3,798,119	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 147,178	$ 28,391	$ 28,391	$	VARIOUS	$ 75,104	71
72	Current Year Purchases	62,159	3,269	3,269		VARIOUS	3,269	72
73	Fully Depreciated Assets	861,007				VARIOUS	861,007	73
74								74
75	TOTALS	$ 1,070,344	$ 31,660	$ 31,660	$		$ 939,380	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANS	DODGE VAN - 1989	1989	$ 25,461	$	$	$	5	$ 25,461	76
77	RESIDENT TRANS	FORD VAN 1996	1996	22,296				5	22,296	77
78	MAINTENANCE	FORD TRUCK 1993	1993	19,169				5	19,169	78
79	RESIDENT TRANS	2003 CHEVY VAN W LIFTS	2002	24,602	4,920	4,920		5	9,840	79
80	TOTALS			$ 91,528	$ 4,920	$ 4,920	$		$ 76,766	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,734,343	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 193,070	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,814,265	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs							4
5	Physician Care	LINE 39(8)	52	visits			24,000		52	24,000	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$		$ 24,000	$	52	$ 24,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number VERMILION MANOR NURSING HOME **#** 0000786 **Report Period Beginning:** 12/01/03 **Ending:** 11/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 781,553	$	1
2	Cash-Patient Deposits	28,994		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000)	930,593		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,741,140	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,572,471		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,161,872		16
17	Accumulated Depreciation (book methods)	(4,814,265)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,920,078	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,661,218	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 246,947	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,994		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	285,793		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO OTHER FUNDS	937,063		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,498,797	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,498,797	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,162,421	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,661,218	$	48

***(See instructions.)**

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,377,118	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,377,118	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(342,754)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PROPERTY - COUNTY CAPITAL FUND	128,057	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (214,697)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,162,421	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,430,505	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,430,505	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	14,982	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,982	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,849	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,849	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS SEE ATTACHED	43,255	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 43,255	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,495,591	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,383,059	31
32	Health Care	5,365,896	32
33	General Administration	766,564	33
	B. Capital Expense		
34	Ownership	195,046	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	127,780	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,838,345	40
41	**Income before Income Taxes (line 30 minus line 40)****	(342,754)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (342,754)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,066	2,327	$ 47,409	$ 20.37	1
2	Assistant Director of Nursing	1,437	1,768	31,716	17.94	2
3	Registered Nurses	43,933	45,891	845,832	18.43	3
4	Licensed Practical Nurses	68,755	72,716	960,099	13.20	4
5	Nurse Aides & Orderlies	211,191	225,421	1,829,787	8.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,685	9,694	85,836	8.85	10
11	Social Service Workers	9,228	10,770	118,858	11.04	11
12	Dietician					12
13	Food Service Supervisor	8,227	9,091	81,461	8.96	13
14	Head Cook	11,117	12,040	99,329	8.25	14
15	Cook Helpers/Assistants	41,474	43,557	244,639	5.62	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,106	17,387	132,471	7.62	18
19	Laundry	14,444	15,426	94,605	6.13	19
20	Administrator	1,992	2,104	63,599	30.23	20
21	Assistant Administrator					21
22	Other Administrative	3,948	4,435	60,811	13.71	22
23	Office Manager					23
24	Clerical	11,616	12,793	94,439	7.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	6,942	1,064	77,176	72.53	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	461,161	486,484	$ 4,868,067 *	$ 10.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 20,338	1/3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,140	10/3	39
40	Physical Therapy Consultant		7,317	10/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) FR&R		5,220	19/3	46
47	COMPUTER SUPPORT		10,591	21/3	47
48					48
49	TOTAL (lines 35 - 48)		$ 44,606		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	800	$ 36,968	10/3	50
51	Licensed Practical Nurses	4,346	146,599	10/3	51
52	Nurse Aides	30	704	10/3	52
53	TOTAL (lines 50 - 52)	5,176	$ 184,271		53

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EDIE HESSER	ADMINISTRATOR	0	$ 63,599
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,599

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	MEDICAL CONSULTANT	$ 5,220
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 5,220

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,999
Unemployment Compensation Insurance	35,985
FICA Taxes	370,902
Employee Health Insurance	126,222
Employee Meals	3,100
Illinois Municipal Retirement Fund (IMRF)*	120,994
GROUP LIFE INSURANCE	13,115
EMPLOYEE PHYSICALS	1,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 727,317

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,330
Advertising: Employee Recruitment	140
Health Care Worker Background Check	
(Indicate # of checks performed 91)	1,180
DUES AND FEES	3,736
BOOKS AND PERIODICALS	1,515
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,901

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/03 Ending: 11/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES, EXCEPT RN'S**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **COUNTY NHA - $1700**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **53,452** Line **10/2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **127,780**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **3,100** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **14,982**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **YES** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **11,721**
c. What percent of all travel expense relates to transportation of nurses and patients? **75%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CLIFTON GUNDERSON LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **NO** If no, please explain. **SEE ATTACHED**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.